

**38 CFR Part 17****RIN 2900-AP02****Civilian Health and Medical Program of the Department of Veterans Affairs**

AGENCY: Department of Veterans Affairs

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with changes, a proposed rule to amend its medical regulations concerning the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The final rule clarifies and updates these regulations to conform to changes in law and policy that control the administration of CHAMPVA and include details concerning the administration of CHAMPVA that were previously not reflected in regulation. The amendments improve our ability to effectively administer CHAMPVA and make technical revisions to make our regulations more understandable. In addition, this rulemaking expands covered services and supplies, to include certain preventive services, and eliminates cost-share amounts and deductibles for certain covered services.

DATES: *Effective date:* This final rule is effective [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

Applicability date: The provisions of this final rule shall apply to all applications for benefits that are received by VA on or after the effective date of this final rule or that are pending before VA, the United States Court of Appeals for Veterans Claims, or the United States Court of Appeals for the Federal Circuit on the effective date of this final rule.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director, Policy and Planning, Office of Integrated Veteran Care (OIVC), 3773 Cherry Creek North Drive,

Denver, Colorado 80209, Joseph.Duran2@va.gov, (303) 370-1637. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: CHAMPVA is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of covered medical care services and supplies with spouses, children, survivors, and certain caregivers of veterans who meet eligibility criteria under 38 U.S.C. 1781. One criterion is that CHAMPVA beneficiaries cannot be eligible for TRICARE, a health care program administered by the Department of Defense (DoD) that is authorized to provide health care to certain family members of veterans. Another criterion is that primary family caregivers designated under 38 U.S.C. 1720G(a)(7)(A) cannot be entitled to services under a health-plan contract as defined in 38 U.S.C. 1725(f).

VA must operate the CHAMPVA program and provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under the CHAMPUS program. See 38 U.S.C. 1781(b). CHAMPUS was the original program administered by DoD to provide civilian health benefits for active duty military personnel, military retirees, and their dependents. See 32 CFR 199.1. Although the CHAMPUS program is still referenced in DoD regulations, DoD effectively replaced the CHAMPUS program with what is commonly known as the TRICARE Select plan ("TRICARE"). See 32 CFR 199.1(r), 199.17(a)(6)(ii)(D) (identifying TRICARE Select as the basic CHAMPUS program). TRICARE's current benefit structure offers varying degrees of medical benefits under multiple plan options beyond its Select plan. However, we administer CHAMPVA in the same or similar manner as TRICARE Select because the basic program is what is referenced by the CHAMPUS authority. Thus, all references in this rulemaking to TRICARE are to the TRICARE Select plan, which we refer to simply as TRICARE throughout most of this rulemaking for ease of reference.

VA interprets the “same or similar manner” language in 38 U.S.C. 1781(b) to mean that we must generally administer CHAMPVA in a same or similar manner as the TRICARE Select plan. We do not interpret this statutory language as requiring VA to operate CHAMPVA in an identical manner to TRICARE. Rather, we interpret this language as affording VA needed flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in the TRICARE Select Plan.

On January 17, 2018, VA proposed to amend its regulations governing CHAMPVA to expand covered services and supplies to include certain preventive services, improve our ability to effectively administer CHAMPVA, and waive cost-shares as well as deductibles for certain covered services. See 83 FR 2396. VA provided a 60-day period during which the public could submit comments to our proposal. The public comment period ended on March 19, 2018, and we received six comments on the proposed rule. Public comments were generally supportive, however several comments suggested substantive changes to the proposed rule. We respond to these public comments here.

§ 17.270 General provisions and definitions.

We proposed amending paragraph (b) by adding definitions for terms used in the CHAMPVA program. We proposed defining an “authorized non-VA provider” to mean an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies who is licensed or certified by a State to provide the covered medical services and supplies, or is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider. We stated that this requirement for State licensure or other certification would be similar to TRICARE, which requires that its providers be either licensed or certified by a State, or,

where States do not offer licensure or certification, be otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider. See TRICARE Policy Manual 6010.60-M, Chapter 11 (“Providers”), section 3.2 (“State Licensure And Certification”).

One commenter generally supported the proposed definition of authorized non-VA provider, and encouraged VA to continue to adopt this language throughout the CHAMPVA regulations to increase consistency and ensure that all healthcare providers, including nurse practitioners, are authorized to provide treatment and services to CHAMPVA members to the full extent of their licensure and certification. To clarify, this rulemaking does not address the scope of practice of health care professionals and does not authorize health care professionals to practice beyond the scope of their state license, certification, or registration. However, we note that CHAMPVA beneficiaries can seek care from qualified nurse practitioners practicing within the scope of their State license and privileges. We thank the commenter for their recommendations and make no changes to the rule based on the comment.

One commenter opposed the inclusion of the language “otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.” The commenter was concerned that this language granted full practice authority to non-physician providers. To clarify, this rulemaking does not grant full practice authority to non-physician providers and does not supersede any State laws. The language was included to address the limited instance where members of a health care occupation or specialty practice area are not governed by a state through its licensure or certification procedures, but instead are governed by the requirements of a national or professional association such as the Joint Commission (previously known as the Joint Commission on Accreditation of Health Care Organizations) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

Changes to paragraph (c). In addition, VA makes technical edits to the rule for clarity. Proposed paragraph (c) addresses VA's discretionary authority to waive certain regulatory requirements. The second sentence of this proposed paragraph states that "it is VA's intent that such discretionary authority would be used only under very unusual and limited circumstances and not to deny any individual any right, benefit, or privilege provided to him or her by statute or these regulations." We are amending proposed paragraph (c) to remove the phrase "It is VA's intent that" at the beginning of the second sentence in the definition as VA does not believe this predicate is necessary. VA is also amending the paragraph by replacing the word "shall" with "will" in the last sentence of the paragraph for clarity.

§ 17.272 Benefits limitations/exclusions.

As part of our reorganization of this section we proposed redesignating multiple subparagraphs in paragraph (a) which addresses exclusions from CHAMPVA coverage, including redesignating paragraph (a)(31) as paragraph (a)(30). This paragraph addresses excluded preventive services from CHAMPVA coverage, except for certain listed services. In addition, we proposed amending two listed exceptions, expanding one exception, and adding three exceptions. The proposed changes are intended to generally align CHAMPVA exceptions with those under TRICARE.

One commenter recommended that VA health plans cover all preventive services with Grade "A" or "B" recommendations from the U.S. Preventive Services Task Force (USPSTF). The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.

Consistent with our mandate to operate the CHAMPVA program in a same or similar manner as TRICARE, we follow TRICARE by adding to our list of covered preventive screenings the following preventive services: colorectal cancer screenings, breast cancer screenings, cervical cancer screenings, prostate cancer screenings, and immunizations. As explained in the proposed rule, TRICARE expanded its program to include certain preventive services, in response to specific statutory requirements. However, for the reasons also explained in the proposed rule, we add annual physical exams to this list, even though not included under TRICARE. 83 FR at 2401. A review of the USPSTF Grade “A” or “B” recommendations reveals that the task force recommends 52 specific preventive medical screenings or interventions, many of which would be part of a routine annual physical examination or otherwise addressed in CHAMPVA preventive services exceptions. Lastly, this rulemaking is limited to amending CHAMPVA regulations, and to the extent this public comment touches on other aspects of VA health care, the recommended changes exceed the scope of this rulemaking.

We proposed redesignating paragraph (a)(51) as paragraph (a)(49). This paragraph excludes food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding, from CHAMPVA coverage.

One commenter asked why CHAMPVA does not cover prescription prenatal vitamins for pregnant beneficiaries when TRICARE provides prenatal vitamins. As stated earlier, CHAMPVA must operate in the same or similar manner to TRICARE. See 38 U.S.C. 1781(b). TRICARE covers medically necessary vitamins used for the management of a covered disease or condition pursuant to a prescription, order, or recommendation of a TRICARE authorized provider acting within the provider's scope of license/certificate of practice. The term "covered disease or condition" includes

pregnancy in relation to prenatal vitamins, with the limitation that the prenatal vitamins that require a prescription in the United States may be covered for prenatal care only. 32 CFR 199.4(d)(3)(vi)(D)(5). We agree that prenatal vitamins should be provided when deemed medically necessary as part of a treatment plan for a pregnant beneficiary. Accordingly, we are amending redesignated paragraph (a)(49), removing the explicit restriction on prenatal care, and amending the paragraph to include clarifying language. As amended, newly redesignated paragraph (a)(49) excludes food, food substitutes, vitamins or other nutritional supplements, including those related to care for a home patient whose condition permits oral feeding, except for prenatal vitamins which are medically necessary as a component of prenatal care and prescribed by a VA provider or an authorized non-VA provider as defined in §17.270.

Previously, smoking cessation services and supplies were specifically excluded from CHAMPVA coverage. In paragraph (a)(76) we proposed that over-the-counter pharmaceutical smoking cessation supplies approved by the U.S. Food and Drug Administration, prescribed, and provided through Medications by Mail (MbM), would not be excluded from CHAMPVA coverage. In a related provision, in 38 CFR 17.270(a)(3)(ii), we proposed that smoking cessation pharmaceutical supplies would be available only through MbM. Smoking cessation supplies would be available to CHAMPVA beneficiaries who are not eligible for Medicare and do not have any other prescription health insurance.

One commenter supported the proposed change but recommended that VA increase opportunities for family physicians and other healthcare clinicians to counsel patients about tobacco cessation. We agree with the commenter and believe that the changes we proposed to CHAMPVA exclusions support efforts to promote smoking cessation. By removing the regulatory restrictions and allowing for smoking cessation services and supplies VA believes it is increasing the opportunities for physicians to

care for beneficiaries who use tobacco products and improving payment for primary care cessation counseling. Under this final rule, smoking cessation counseling, including coverage of pharmaceuticals, is a covered benefit when CHAMPVA is the primary payer and any prescribed, FDA-approved smoking cessation pharmaceutical products are delivered through MbM. This mirrors TRICARE, which covers smoking cessation pharmaceutical products only when delivered through its mail order pharmacy program. Thus, we are covering these services in a similar manner to TRICARE. Additionally, by providing smoking cessation products through MbM, the beneficiary avoids any CHAMPVA cost-sharing amounts which might otherwise apply if purchased through a retail pharmacy. We make no changes based on this comment.

§ 17.273 Preauthorization.

We proposed revising preauthorization requirements by adding language to indicate when a beneficiary has “other health insurance” that provides primary coverage for the benefit, preauthorization requirements will not apply. To provide benefits in a similar fashion as TRICARE we proposed waiving any requirement for preauthorization where other health insurance covers the benefit. In addition, we proposed removing the requirement for preauthorization for durable medical equipment (DME) as a covered service or supply.

One commenter encouraged VA to apply prior authorization principles in CHAMPVA and other health plans under VA’s purview such as: activities requiring prior authorization must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control; prior authorization should be eliminated for physicians with aligned financial incentives (e.g., shared savings) and proven successful stewardship; and eliminate prior authorization for DME, imaging, supplies, and generic drugs. To the extent this comment addresses

health care provided by VA other than CHAMPVA, it focuses on issues beyond the scope of this rulemaking. VA follows guidelines in its CHAMPVA regulations specifying the need for prior authorization under specific sets of circumstances. Also, with the removal of prior authorization for DME in this final rule, CHAMPVA no longer requires preauthorization for DME, imaging, supplies, or generic drugs. Whenever prior authorization is required, however, we note that VA always determines need based on the best interest of the beneficiaries we serve.

In addition, the commenter recommended the VA apply transitional steps for changing preauthorization requirements, and offered suggestions primarily related to VA's relationship to VA contractors. Generally, CHAMPVA does not engage VA contractors to provide health care to CHAMPVA beneficiaries. The only instance where a CHAMPVA beneficiary could possibly receive care from a VA contractor working in that capacity is where a beneficiary who is not eligible for Medicare receives care in a VA medical facility on a space available basis through the CHAMPVA In-house Treatment Initiative (CITI). In that instance, if the VA provider is operating in the VA medical facility on a contractual basis the provider works under the same rules as a health care provider who is a VA employee. The transitional steps listed by the commenter are beyond the scope of this rulemaking, and we make no changes based on this comment.

§ 17.274 Cost sharing.

This section addresses cost sharing and deductibles. Proposed paragraph (b) focuses on annual deductibles (\$50 per beneficiary or \$100 per family) as well as instances where the deductible is waived. One commenter expressed concern with the patients' inability to afford medically necessary care. The commenter stated that the escalation in deductibles is limiting access to care, and higher deductibles create a

financial disconnect between individuals, their primary care physician, and the broader health care system. CHAMPVA does not have a high deductible plan but an annual deductible of \$50 per beneficiary or \$100 per family. CHAMPVA deductible amounts have not escalated and have remained unchanged since at least 1999. The commenter's general concern regarding escalating deductibles limiting access to care does not apply to the CHAMPVA program. We make no changes based on this comment.

However, we are making one minor edit to paragraph (a)(1)(v) to clarify that CHAMPVA beneficiary cost-share requirements do not apply to various other preventive services as determined by the Secretary of Veterans Affairs. VA determined that this subparagraph was not specific enough in that it did not specify that "preventive" services as determined by the Secretary is not subject to CHAMPVA beneficiary cost-share requirements.

§ 17.275 CHAMPVA determined allowable amount calculation.

We proposed adding a new § 17.275 to describe the various payment methodologies used by CHAMPVA to calculate the CHAMPVA determined allowable amount for covered services and supplies. We stated that CHAMPVA uses the same or similar payment methodologies to establish allowable reimbursement amounts for providers as TRICARE, and that proposed payment methodologies would be consistent with current VA practice.

One commenter expressed concerns regarding CHAMPVA's non-VA provider reimbursement amounts not being equal to Medicare reimbursement amounts in response to CHAMPVA's clarification of a provider accepting assignment. When feasible, CHAMPVA determines its allowable charges using TRICARE's reimbursement

methodologies. In this instance, CHAMPVA uses TRICARE's physician fee schedule, which is equivalent to Medicare's physician fee schedule, to determine the CHAMPVA Maximum Allowable Charge. Additionally, this commenter stated that VA should offer contracts at least at the Medicare rate, so family physicians and other non-VA entities can afford to treat veterans. CHAMPVA does not contract with providers to treat veterans. CHAMPVA is a family member health benefits program for dependents of permanently and totally disabled and certain other veterans and certain caregivers. Under it, VA uses the TRICARE physician fee schedule amount, which is equivalent to the Medicare physician fee schedule amount, to determine the CHAMPVA Maximum Allowable Charge. We make no changes based on this comment.

Proposed paragraph (h) provided that reimbursement for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) would be based on the same amounts established under the Centers for Medicare & Medicaid Services (CMS) DMEPOS fee schedule under 42 CFR part 414, subpart D, which is the same methodology used in TRICARE regulations to calculate DMEPOS payments. See 32 CFR 199.14(k). The allowed amount would be that which is in effect in the specific geographic location at the time CHAMPVA-covered services and supplies are provided to a CHAMPVA beneficiary.

One commenter urged VA to review Medicare's current policies related to the Medicare benefit for DMEPOS to evaluate potential access to care for our beneficiaries. The commenter stated that Medicare's fee schedules in non-competitive bidding areas, which are based on single payment amounts, results in reduced access to DMEPOS and inadequate payment to suppliers. Although we understand the commenter's concern, we chose to revise our regulations to be consistent with the Medicare fee schedule because TRICARE uses the Medicare fee schedule. Also, we believe that matching TRICARE payment methodologies as closely as possible is the best way to

provide for medical care in the same or similar manner as TRICARE pursuant to 38 U.S.C. 1781(b). The rates at which VA pays for care are an integral part of the “provision” of care, and therefore, we think this is an area where VA should remain in line with TRICARE. We thank the commenter for their suggestion, but make no changes to the rule based on this comment.

In paragraph (j) we proposed establishing in regulation the current CHAMPVA reimbursement methodology for hospice care. This methodology uses rates in the CMS hospice per diem rate payment system, which is the same methodology used in TRICARE regulations to calculate hospice payments. See 32 CFR 199.14(g)(9).

One commenter inquired whether CHAMPVA will use Medicare rates for each year by hospice level of care, including two tiers of payment for routine home care. Although TRICARE regulations do not reflect the two-tiered payment system, it is reflected in its reimbursement manual. See TRICARE Reimbursement Manual 6010.61-M, April 1, 2015, Chapter 11, Section 4, Subsection 3.1.1.3. TRICARE implemented the two-tiered payment rates for routine home care (RHC) levels of care effective January 1, 2016. CHAMPVA cannot, however, implement the two-tiered payment system due to current IT system limitations. We will consider adopting this methodology in the future, dependent on increased system capabilities. CHAMPVA already uses Medicare’s annual hospice rates and utilizes Medicare’s rates for each level of hospice service, with the exception of the “61-day and over” routine home care (RHC) rates. For RHC, CHAMPVA currently only reimburses Medicare’s 1-60 day RHC rate for all routine home care days, regardless of the number of days RHC is provided. For RHC provided for 61 days or more, CHAMPVA reimburses at a higher rate than allowable under Medicare rules. The final rule codifies these practices.

In addition, the commenter asked how CHAMPVA will track any updates that Medicare makes in the structure of its hospice payment system. CHAMPVA annually reviews Medicare's hospice proposed rules and final rules in the Federal Register to maintain awareness of any potential change in TRICARE reimbursement methodologies. If TRICARE implements any Medicare reimbursement updates in the future, CHAMPVA will assess the feasibility of implementing such changes.

The commenter inquired as to whether changes in the hospice payment structure by CMS are mirrored by CHAMPVA in the same time frame as Medicare. CHAMPVA is not based on the Medicare program, but instead must operate in the same or similar manner as TRICARE.

Finally, the commenter asked about communication regarding hospice updates to Veterans Integrated Service Networks (VISNs) and local VA facilities and offered suggestions for improving communications. Internal VA processes, including avenues of communication between a VA medical facility and the VISN, are not typically addressed via regulation. Rather, internal processes and procedures are more properly delineated in agency policy. We make no changes to this rulemaking based on these comments.

Changes to paragraph (g). In addition, we are making a technical edit to paragraph (g). In the proposed rule, we proposed revising this paragraph to state that the CHAMPVA Skilled Nursing Facility (SNF) care reimbursement methodology is based on the CMS Prospective Payment System for SNFs under 42 CFR part 413, subpart J (Medicare Resource Utilization Group (RUG) rates). See 83 FR 2411. Medicare replaced the RUG rates in fiscal year 2020 with Patient Driven Payment Model (PDPM) rates. Therefore, in this rulemaking, we are removing the phrase "Medicare Resource Utilization Group (RUG) rates" in the parenthetical. We note that

the PDPM reporting mechanism decreases the administrative burden on providers but does not impact reimbursement rates. VA makes no other changes in this paragraph.

Changes to paragraph (k). We are also making a technical edit to paragraph (k) to conform with minor changes to Medicare payment methodologies that went into effect after the public comment period closed. In the proposed rule, we proposed revising paragraph (k) to state that the CHAMPVA home health care reimbursement methodology, based on Medicare's home health prospective payment system, uses a fixed case-mix and wage-adjusted national 60-day episode payment amount to act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established. See 83 FR 2396. Additionally, we explained that we would make the change of adopting TRICARE's reimbursement methodology for intermittent or part-time home health services, which itself is based on Medicare's reimbursement methodology. In other words, the proposed substantive rule for this paragraph is that CHAMPVA will reimburse these services in a manner similar to TRICARE, which adopts Medicare's methodology. We received no comments on proposed 17.275(k).

Since the proposed rule was published (January 17, 2018), Medicare has finalized changes that change aspects of its methodology for paying for home health services. More specifically, on November 13, 2018, CMS published a final rule with comment period (RIN 0938-AT29) that amended 42 CFR Part 484 to, inter alia, update the Home Health Prospective Payment System (HH PPS) payment methodology, effective January 1, 2020. See 83 FR 56406. Of relevance here, that CMS final rule changed its regulations from requiring a 60-day episode payment to a 30-day episode payment.

The "60-day episode of care" language in the proposed rule at 38 CFR 17.275(k) referred to the substantive content in that paragraph, which was the proposed use of

Medicare's HH PPS payment methodology when determining payment for intermittent or part-time home health care consistent with that used by TRICARE. The inclusion of the reference to the length of the episode of care was intended to be informative in nature and aligned with Medicare rules as of the date the proposed rule published. In this final rulemaking we are not changing the payment methodology that CHAMPVA utilizes when determining payment for intermittent or part-time home health care. However, we are removing the reference to a specific episode of care length in reference to Medicare's HH PPS payment methodology, which no longer uses a 60-day episode of care. As discussed above, Medicare has adopted a 30-day episode of care in its final rule, effective January 1, 2020 (see RIN 0938-AT39 (83 FR 56406) published November 13, 2018). Removing reference to a specific length for an episode of care as it relates to payment for intermittent or part time home health care will preserve needed flexibility to adequately implement and update our HH PPS in a manner consistent with any changes made by TRICARE. The public was fairly apprised of the potential scope and substance of the proposed rule – that we would be using Medicare's HH PPS payment methodology for payment for intermittent or part time home health care, and that remains the same in the final rule. This rulemaking revises paragraph (k) to state that the CHAMPVA home health care reimbursement methodology, based on TRICARE's home health prospective payment system, uses a fixed case-mix and wage-adjusted episode payment amount to act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established. Because the proposed substantive rule for paragraph (k) is unchanged here, removing the detail describing how it is currently calculated under Medicare is a technical fix to avoid the need for future updates of such details.

§ 17.277 Appeals.

This section addresses appeals. If a CHAMPVA beneficiary or provider disagrees with a determination concerning CHAMPVA-covered services and supplies or calculation of benefits, a request for reconsideration may be made. If the beneficiary or provider disagrees with the reconsideration determination, the denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals (BVA). Although we received no public comments on this section, changes are necessary to address issues raised by the Veterans Appeals Improvement and Modernization Act of 2017 (Public Law 115-55) ("the AMA"). The AMA revised processes for resolving VA benefits claims and appeals of VA benefits decisions. In February 2019, VA promulgated rules to implement the AMA under 38 CFR parts 3 and 8, 14, 19, 20, and 21. 84 FR 138 (January 18, 2019).

On February 21, 2020, VA published a proposed rule to revise several sections of 38 CFR part 17 including 17.276. See 85 FR 10118. In that proposed rule, we updated 38 CFR 17.276 to reflect that reconsideration within the VHA appeals process is only available in legacy claims. *Id.* The comment period ended on April 21, 2020. VA received no comments on the proposed changes to 17.276. Given the effect these changes have on the CHAMPVA program, VA adopts the proposed changes to 17.276 from 85 FR 10118 in this rulemaking and redesignates the section as 17.277.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. The final payment methods in this rulemaking will include new reimbursement rates for the Outpatient Prospective Payment System (OPPS), Home Health Prospective Payment System (HH PPS), and Sole Community Hospitals (SCHs) reimbursement methodologies. These revised methodologies will not significantly affect small businesses due to the following reasons: (1) The health care industry, to include Medicare and TRICARE, is currently using these payment methods and most providers are used to these reimbursement rates, if not expecting to receive them; (2) CHAMPVA's beneficiary population is relatively small compared to these other health care payers. On this basis, the Secretary certifies that the adoption of this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined this rule to be a significant regulatory action under

Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on state, local, or tribal governments, or on the private sector.

Assistance Listing

The Assistance Listing numbers and titles for the programs affected by this document are 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; and 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; and 64.019, Veterans Rehabilitation Alcohol and Drug Dependence.

Congressional Review Act

This regulatory action is a major rule under the Congressional Review Act, 5 U.S.C. 801-808, because it may result in an annual effect on the economy of \$100 million or more. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this Regulation and the Regulatory Impact Analysis (RIA) associated with the Regulation.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on October 8, 2021, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulations Development Coordinator,
Office of Regulation Policy & Management,
Office of General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs (VA) amends 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. The general authority citation for part 17 continues and authority citations for §§ 17.270, 17.271, 17.278 and 17.279 are added in numerical order to read as follows to read as follows

38 U.S.C. 501, and as noted in specific sections.

Sections 17.270, and 17.272 through 17.277 are also issued under 38 U.S.C. 1781.

Section 17.271 is also issued under 38 U.S.C. 1720G(a)(7)(A) and 1781.

Section 17.278 is also issued under 38 U.S.C. 1781 and 42 U.S.C. 2651.

Section 17.279 is also issued under 5 U.S.C. 552 and 552a; 38 U.S.C. 1781, 5701, and 7332.

2. Revise § 17.270 to read as follows:

§ 17.270 General provisions and definitions.

(a) *Overview of CHAMPVA.* CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs (VA). Generally, CHAMPVA furnishes medical care in the same or similar manner, and subject to the same or similar limitations, as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under chapter 55 of title 10, United States Code (CHAMPUS), commonly referred to as the TRICARE Select plan. Under CHAMPVA, VA shares the cost of medically necessary services and supplies with eligible beneficiaries within the 50 United States, the District of Columbia, the U.S.

territories, and abroad. Under CHAMPVA, medical services and supplies may be provided as follows:

(1) By an authorized non-VA provider.

(2) By a VA provider at a VA facility, on a resource-available basis through the CHAMPVA In-house Treatment Initiative (CITI) to CHAMPVA beneficiaries who are not also eligible for Medicare.

(3) Through VA Medications by Mail (MbM).

(i) Only CHAMPVA beneficiaries who do not have any other type of health insurance that pays for prescriptions, including Medicare Part D, may use MbM.

(ii) Smoking cessation pharmaceutical supplies will only be provided through MbM and only to CHAMPVA beneficiaries that are not also eligible for Medicare.

(b) *Definitions.* The following definitions apply to CHAMPVA (§§ 17.270 through 17.278):

Accepted assignment refers to the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. (The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider with the exception of applicable cost-shares and deductibles.)

Authorized non-VA provider means an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies that meets any of the following criteria:

(i) Is licensed or certified by a state to provide the medical services and supplies;

or

(ii) Where a state does not offer licensure or certification, is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.

Calendar year means January 1 through December 31.

CHAMPVA beneficiary means a person enrolled under § 17.271.

CHAMPVA-covered services and supplies mean those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under § 17.272(a)(1) through (84).

CHAMPVA determined allowable amount has the meaning set forth in § 17.272(b)(1).

CHAMPVA In-house Treatment Initiative (CITI) means the initiative under 38 U.S.C. 1781(b) under which participating VA medical facilities provide medical services and supplies to CHAMPVA beneficiaries who are not also eligible for Medicare, subject to availability of space and resources.

Child has the definition established in 38 U.S.C. 101.

Claim means a request by an authorized non-VA provider or by a CHAMPVA beneficiary for payment or reimbursement for medical services and supplies provided to a CHAMPVA beneficiary.

Fiscal year means October 1 through September 30.

Medications by Mail (MbM) means the initiative under which VA provides outpatient prescription medications through the mail to CHAMPVA beneficiaries.

Other health insurance (OHI) means health insurance plans or programs (including Medicare) or third-party coverage that provide coverage to a CHAMPVA beneficiary for expenses incurred for medical services and supplies.

Payer refers to OHI, as defined in this section, that is obligated to pay for CHAMPVA-covered medical services and supplies. In a situation in which, in addition

to CHAMPVA, one or more payers is/are responsible to pay for such services and supplies (i.e., a “double coverage” situation), there would be a primary payer (i.e., the payer obligated to pay first), secondary payer (i.e., the payer obligated to pay after the primary payer), etc. In double coverage situations, CHAMPVA would be the last payer.

Service-connected has the definition established in 38 U.S.C. 101.

Spouse refers to a person who is married to a veteran and whose marriage is valid as determined under 38 U.S.C. 103(c).

Surviving spouse refers to a person who was married to and is the widow(er) of a veteran as determined under 38 U.S.C. 103(c).

(c) *Discretionary authority.* When it is determined to be in the best interest of VA, VA may waive any requirement in §§ 17.270 through 17.278, except any requirement specifically set forth in 38 U.S.C. 1781, or otherwise imposed by statute. Such discretionary authority would be used only under very unusual and limited circumstances and not to deny any individual any right, benefit, or privilege provided to him or her by statute or these regulations. Any such waiver will apply only to the individual circumstance or case involved and will in no way be construed to be precedent-setting.

3. Amend § 17.271 by:

- a. Removing the word “and” at the end of paragraph (a)(3);
- b. Redesignating paragraph (a)(4) as paragraph (a)(5);
- c. Adding a new paragraph (a)(4);
- d. Removing the authority citation following paragraph (a); and
- e. Removing the authority citation following paragraph (b)(5).

The addition and revision read as follows:

§ 17.271 Eligibility.

(a) * * *

(4) An individual designated as a Primary Family Caregiver, under 38 CFR 71.25(f), who is not entitled to care or services under a health-plan contract (as defined in 38 U.S.C. 1725(f)(2)); and

* * * * *

4. Amend § 17.272 by:

- a. Revising paragraph (a)(2);
- b. In paragraph (a)(3) introductory text, removing the phrase “(Medicaid excluded)”;
- c. Adding paragraphs (a)(3)(iii) and (iv);
- d. Revising paragraph (a)(21)(ix);
- e. Removing paragraph (a)(26);
- f. Redesignating paragraphs (a)(27) through (38) as paragraphs (a)(26) through (37), respectively;
- g. In newly redesignated paragraph (a)(30), revising the introductory text and paragraphs (a)(30)(v) and (vi) and adding paragraphs (a)(30)(xi) through (xiv);
- h. Removing paragraph (a)(39);
- i. Redesignating paragraphs (a)(40) through (56) as paragraphs (a)(38) through (54), respectively;
- j. In newly redesignated paragraph (a)(40)(iv), removing “(a)(42)(iii)(A)” and adding in its place “(a)(40)(iii)(A)”;
- k. Revising redesignated paragraph (a)(49);
- l. Removing paragraph (a)(57);
- m. Redesignating paragraphs (a)(58) through (71) as paragraphs (a)(55) through (68), respectively;
- n. Revising newly redesignated paragraphs (a)(57) through (59);
- o. Removing paragraph (a)(72);

p. Redesignating paragraphs (a)(73) through (86) as paragraphs (a)(69) through (82), respectively;

q. Revising newly redesignated paragraph (a)(76);

r. Adding paragraphs (a)(83) and (84);

s. Revising paragraph (b); and

t. Removing the authority citation at the end of the section.

The revisions and additions read as follows:

§ 17.272 Benefits limitations/exclusions.

(a) * * *

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or paid) except when such benefits are exhausted and the services and supplies are otherwise not excluded from CHAMPVA coverage.

(3) * * *

(iii) Indian Health Service.

(iv) CHAMPVA supplemental policies.

* * * * *

(21) * * *

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint disorder (TMD). Authorization is limited to initial imaging such as radiographs, Computed Tomography, or Magnetic Resonance Imaging; up to four office visits; and the construction of an occlusal splint.

* * * * *

(30) Preventive care (such as employment-requested physical examinations and routine screening procedures). The following exceptions apply, including but not limited to:

* * * * *

(v) Cervical cancer screening.

(vi) Breast cancer screening.

* * * * *

(xi) Colorectal cancer screening.

(xii) Prostate cancer screening.

(xiii) Annual physical examination.

(xiv) Vaccinations/immunizations.

* * * * *

(49) Food, food substitutes, vitamins or other nutritional supplements, including those related to care for a home patient whose condition permits oral feeding, except for prenatal vitamins which are medically necessary as a component of prenatal care and prescribed by a VA provider or an authorized non-VA provider as defined in §17.270 of this part.

* * * * *

(57) Unless a waiver for extended coverage is granted in advance: Inpatient mental health services in excess of 30 days in any calendar year (or in an admission), in the case of a patient 19 years of age or older; 45 days in any calendar year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any calendar year (or in an admission).

(58) Outpatient mental health services in excess of 23 visits in a calendar year unless a waiver for extended coverage is granted in advance.

(59) Institutional services for partial hospitalization in excess of 60 treatment days in any calendar year (or in an admission) unless a waiver for extended coverage is granted in advance.

* * * * *

(76) Over-the-counter products except for pharmaceutical smoking cessation supplies that are approved by the U.S. Food and Drug Administration, prescribed, and provided through MbM, and insulin and related diabetic testing supplies and syringes.

* * * * *

(83) Medications not approved by the U.S. Food and Drug Administration (FDA), excluding FDA exceptions to the approval requirement.

(84) Services and supplies related to the treatment of dyslexia.

(b) Costs of services and supplies to the extent such amounts are billed over the CHAMPVA determined allowable amount are specifically excluded from coverage.

(1) The CHAMPVA determined allowable amount is the maximum level of payment by CHAMPVA to an authorized non-VA provider for the provision of CHAMPVA-covered services and supplies to a CHAMPVA beneficiary. The CHAMPVA determined allowable amount is determined before consideration of cost sharing and the application of deductibles or OHI.

(2) A Medicare-participating hospital must accept the CHAMPVA determined allowable amount for inpatient services provided to a CHAMPVA beneficiary as payment in full. See 42 CFR 489.25.

(3) An authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary (i.e., accepted assignment). The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider. Any

attempts to collect any additional amount from the CHAMPVA beneficiary may result in the provider being excluded from Federal benefits programs. See 42 CFR 1003.105.

5. Amend § 17.273 by:

- a. Revising the introductory text and paragraph (d);
- b. Removing paragraph (e);
- c. Redesignating paragraph (f) as paragraph (e);
- d. Adding new paragraph (f); and
- e. Removing the authority citation at the end of the section.

The revisions and addition read as follows:

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following, except when the benefit is covered by the CHAMPVA beneficiary's other health insurance (OHI):

* * * * *

(d) Dental care. For limitations on dental care, see § 17.272(a)(21)(i) through (xii).

* * * * *

(f) CHAMPVA will perform a retrospective medical necessity review during the coordination of benefits process if:

(1) It is determined that CHAMPVA is the responsible payer for services and supplies but CHAMPVA preauthorization was not obtained prior to delivery of the services or supplies; and,

(2) The claim for payment is filed within the appropriate one-year period.

6. Amend § 17.274 by:

- a. Revising paragraphs (a), (b), and (c);

- b. Adding a heading to paragraph (d);
- c. Adding paragraph (e); and
- d. Removing the authority citation at the end of the section.

The revisions and additions read as follows:

§ 17.274 Cost sharing.

(a) *Cost sharing generally.* CHAMPVA is a cost sharing program in which the cost of covered services is shared with the CHAMPVA beneficiary. CHAMPVA pays the CHAMPVA determined allowable amount less the CHAMPVA deductible, if applicable, and less the CHAMPVA beneficiary cost-share.

(1) CHAMPVA beneficiary cost-share requirements do not apply to the following:

(i) Supplies provided through VA MbM.

(ii) Any medical services and supplies provided to a CHAMPVA beneficiary through CITI.

(iii) The following services, even if not provided through CITI:

(A) Colorectal cancer screening.

(B) Breast cancer screening.

(C) Cervical cancer screening.

(D) Prostate cancer screening.

(E) Annual physical exams.

(F) Vaccinations/immunizations.

(G) Well child care from birth to age six, as described in § 17.272(a)(30)(i).

(iv) Hospice services.

(v) Or other preventive services as determined by the Secretary of Veterans Affairs.

(2) [Reserved]

(b) *Deductibles.* In addition to the CHAMPVA beneficiary cost-share, an annual (calendar year) outpatient deductible requirement (\$50 per beneficiary or \$100 per family) must be satisfied prior to VA payment of outpatient benefits. The deductible requirement is waived for:

(1) CHAMPVA-covered services and supplies provided through VA MbM or through CITI.

(2) Inpatient services.

(3) Preventive services listed in paragraph (a)(1)(iii) of this section.

(4) Hospice services.

(5) Or other services as determined by the Secretary of Veterans Affairs.

(c) *Cost sharing limitations.* To provide financial protection against the impact of a long-term illness or injury, there is a \$3,000 calendar year limit or “catastrophic cap” per CHAMPVA eligible family on the CHAMPVA beneficiary’s out-of-pocket costs for allowable services and supplies. After a family has paid \$3,000 in out-of-pocket costs, to include both cost-share and deductible amounts, in a calendar year, CHAMPVA will pay the full allowable amounts for the remaining CHAMPVA-covered services and supplies through the end of that calendar year. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the CHAMPVA beneficiary cost-share amount. Costs above the CHAMPVA determined allowable amount, as well as costs associated with non-covered medical services and supplies, are not credited toward the catastrophic cap calculation.

(d) *Non-payment.* * * *

(e) *Cost-share calculation.* The CHAMPVA beneficiary’s cost-share amount, if not waived under paragraph (a)(1) of this section, is 25 percent of the CHAMPVA determined allowable amount in excess of the annual calendar year deductible (see §

17.275 for procedures related to the calculation of the allowable amount for CHAMPVA-covered services and supplies), except for the following:

(1) For inpatient services subject to the CHAMPVA Diagnosis Related Group (DRG) payment system, the cost-share is the lesser of:

- (i) The per diem rate multiplied by the number of inpatient days;
- (ii) 25 percent of the hospital's billed amount; or
- (iii) The base CHAMPVA DRG rate.

(2) For inpatient mental health low volume hospitals and units (less than 25 mental health discharges per federal fiscal year), the cost-share is the lesser of:

- (i) The fixed per diem rate multiplied by the number of inpatient days; or
- (ii) 25 percent of the hospital's billed charges.

7. Redesignate §§ 17.275 through 17.278 as §§ 17.276 through 17.279.

8. Add new § 17.275 to read as follows:

§ 17.275 CHAMPVA determined allowable amount calculation.

CHAMPVA calculates the allowable amount in the following ways, for the following covered services and supplies:

(a) *Inpatient hospital services (non-mental health)*. Unless exempt or subject to a methodology under paragraph (b) or (c) of this section, inpatient hospital services provided in the 50 states, the District of Columbia, and Puerto Rico are subject to the CHAMPVA Diagnosis Related Group (DRG)-based reimbursement methodology.

Under the CHAMPVA DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services, which will not exceed the billed amount. Certain inpatient services will be reimbursed under the CHAMPVA Cost-to-Charge (CTC) reimbursement methodology.

(b) *Inpatient hospital services (mental health)*. The CHAMPVA inpatient mental health per diem reimbursement methodology is used to calculate reimbursement for

inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the CHAMPVA DRG-based payment system. The per diem rate is calculated by multiplying the daily rate by the number of days (length of stay). The daily rate is updated each fiscal year for both high volume hospitals (25 or more discharges per fiscal year) and low volume hospitals (fewer than 25 discharges per fiscal year).

(c) *Other inpatient hospital services.* (1) The CHAMPVA CTC reimbursement methodology is used to calculate reimbursement for inpatient care furnished by hospitals or facilities that are exempt from either of the methodologies in paragraph (a) or (b) of this section. Such hospitals or facilities will be paid at the CHAMPVA CTC ratio times the billed charges that are customary and not in excess of rates or fees the hospital or facility charges the general public for similar services in a community.

(2) The following hospitals and services are subject to the CHAMPVA CTC payment methodology:

(i) Any hospital that qualifies as a cancer hospital under Medicare standards and has elected to be exempt from the Centers for Medicare & Medicaid Services (CMS) prospective payment system.

(ii) Christian Science sanatoriums.

(iii) Critical Access Hospitals.

(iv) Any hospital outside the 50 states, the District of Columbia, or Puerto Rico.

(v) Hospitals within hospitals.

(vi) Long-term care hospitals.

(vii) Non-Medicare participating hospitals.

(viii) Non-VA Federal Health Care Facilities (e.g., military treatment facilities, Indian Health Service).

(ix) Rehabilitation hospitals.

(x) Hospital or hospital-based services subject to state waiver in any state that has implemented a separate DRG-based payment system or similar payment system in order to control costs.

(xi) Hospitals and services as determined by the Secretary of Veterans Affairs.

(d) *Outpatient hospital services.* The CHAMPVA outpatient prospective payment system (OPPS) is used to calculate the allowable amount for outpatient services provided in hospitals subject to Medicare OPPS. This will include the utilization of TRICARE's reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts, and associated adjustments.

(e) *Outpatient and inpatient non-hospital services.* Payments to individual authorized non-VA providers (not hospitals) for CHAMPVA-covered medical services and supplies provided on an outpatient or inpatient basis, including but not limited to, anesthesia services, laboratory services, and other professional fees associated with individual authorized non-VA providers, are reimbursed based on the lesser of:

- (1) The CHAMPVA Maximum Allowable Charge;
- (2) The prevailing amount, which is the amount equal to the maximum reasonable amount allowed providers for a specific procedure in a specific locality; or,
- (3) The billed amount.

(f) *Pharmacy services and supplies.* The CHAMPVA pharmacy services and supplies payment methodology is based on specific CHAMPVA pharmacy points of service, which dictate the amounts paid by VA. VA pays:

- (1) For services and supplies obtained from a retail in-network pharmacy, the lesser of the billed amount or the contracted rate; or

(2) For supplies obtained from a retail out-of-network pharmacy, the lesser of the billed amount plus a dispensing fee or the average wholesale price plus a dispensing fee.

(g) *Skilled Nursing Facility (SNF) care.* The CHAMPVA SNF reimbursement methodology is based on the CMS prospective payment system for SNFs under 42 CFR part 413, subpart J.

(h) *Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).* The CHAMPVA DMEPOS reimbursement methodology is based on the same amounts established under the CMS DMEPOS fee schedule under 42 CFR part 414, subpart D. The CHAMPVA determined allowable amount for DMEPOS is the amount in effect in the specific geographic location at the time CHAMPVA-covered medical services and supplies are provided to a CHAMPVA beneficiary.

(i) *Ambulance services.* CHAMPVA adopts Medicare's Ambulance Fee Schedule (AFS) for ambulance services, with the exception of services furnished by a Critical Access Hospital (CAH). Ambulance services are paid based on the lesser of the Medicare AFS or the billed amount. Ambulance services provided by a CAH are paid on the same bases as the CTC method under paragraph (c) of this section.

(j) *Hospice care.* CHAMPVA hospice reimbursement methodology uses Medicare per diem hospice rates.

(k) *Home health care (intermittent or part-time).* CHAMPVA home health care reimbursement methodology, based on Medicare's home health prospective payment system, uses a fixed case-mix and wage-adjusted episode payment amount to act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established.

(l) *Ambulatory surgery.* The CHAMPVA reimbursement methodology for facility charges associated with procedures performed in a freestanding ambulatory surgery

center is based on a prospectively determined amount, similar to that used by TRICARE. These facility charges do not include physician fees, anesthesiologist fees, or fees of other authorized non-VA providers; such independent professional fees must be submitted separately from facility fees and are calculated under the methodology in paragraph (e) of this section.

(m) *CHAMPVA-covered medical services and supplies provided outside the United States.* VA shall determine the appropriate reimbursement method(s) for CHAMPVA-covered medical services and supplies provided by authorized non-VA providers outside the United States.

(n) *Sole Community Hospitals.* The CHAMPVA reimbursement methodology for inpatient services provided in a Sole Community Hospital (SCH) will be the greater of: the allowable amount determined by multiplying the billed charges by the SCH's most recently available cost-to-charge ratio from the CMS Inpatient Provider Specific File or the DRG reimbursement rate.

9. Amend newly redesignated § 17.276 by:

- a. Revising paragraphs (a) introductory text and (b);
- b. Adding paragraphs (c) and (d); and
- c. Removing the authority citation at the end of the section.

The revisions and additions read as follows:

§ 17.276 Claim-filing deadlines.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed no later than:

* * * * *

(b) Requests for an exception to the claim filing deadline must be submitted in writing and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the

claim filing deadline will be reviewed individually and considered on its own merit. VA may grant exceptions to the requirements in paragraph (a) of this section if it determines that there was good cause for missing the filing deadline. For example, when dual coverage exists, CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

(c) Claims for CHAMPVA-covered services and supplies provided before the date of the event that qualifies an individual under § 17.271 are not reimbursable.

(d) CHAMPVA is the last payer to OHI, as that term is defined in § 17.270(b). CHAMPVA benefits will generally not be paid until the claim has been filed with the OHI and the OHI has issued a final payment determination or explanation of benefits. CHAMPVA is secondary payer to Medicare per the terms of § 17.271(b).

10. Revise newly redesignated § 17.277 to read as follows:

§ 17.277 Appeals.

(a) This section applies only to legacy claims.

(b) Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the CHAMPVA beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a CHAMPVA beneficiary or provider disagrees with the determination concerning CHAMPVA-covered services and supplies or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to VA in writing within one year of the date of the initial determination. The request must state why the CHAMPVA claimant believes the decision is in error and must include any new and relevant information not previously considered. Any request for

reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. If the claimant is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by VA. After reviewing the claim and any relevant supporting documentation, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. The decision of VA with respect to benefit coverage and computation of benefits is final. When a CHAMPVA beneficiary has other health insurance (OHI), an appeal must first be filed with the OHI, and a determination made, before submitting the appeal to CHAMPVA with limited exceptions such as if the OHI deems the issue non-appealable. Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 38 CFR 20.101.

11. Revise newly redesignated § 17.278 to read as follows:

§ 17.278 Medical care cost recovery.

VA will actively pursue medical care cost recovery in accordance with applicable law.

§ 17.279 [Amended]

12. In newly redesignated § 17.279, remove the authority citation at the end of the section.